

Mental Health Guidelines and Billing Practices

HP Provider Relations
July 2011

Agenda

- Session Objectives
- Outpatient Mental Health
- Medicaid Rehabilitation Option (MRO)
- Risk-Based Managed Care (RBMC)
- Eligibility Inquiry
- Web interChange and CMS-1500 Billing Guidelines
- Helpful Tools
- Questions

Objectives

At the end of this presentation, providers will understand the following:

- Outpatient coverage requirements
- MRO services
- Meaning of rolling 12-month period
- Role of the health service provider in psychology (HSPP)
- Managed care carve-in
- How to verify member eligibility
- How to submit claims via the Web interChange and the CMS-1500 claim form



Understand

Outpatient Mental Health

Mental Health

- The Indiana Health Coverage Programs (IHCP) under the direction of the Indiana Administrative Code (IAC) 405 IAC 5-20-8 reimburses for outpatient mental health services when provided by:
 - Licensed physicians
 - Psychiatric hospitals
 - Psychiatric wings of acute care hospitals
 - Outpatient mental health facilities
 - Licensed psychologists with the HSPP designation



Mental Health

- The IHCP also reimburses under *405 IAC 5-20-8* for psychiatrist or HSPP-directed outpatient mental health services when provided by mid-level practitioners:
 - Licensed clinical social worker (LCSW)
 - A person holding a masters degree in social work (MSW), marital and family therapy or mental health counseling , except that partial hospitalization services provided by such person shall not be reimbursed
 - Licensed psychologist
 - Licensed independent practice school psychologist
 - Licensed marriage and family therapist (LMFT)
 - Licensed mental health counselor (LMHC)
 - An Advanced practice nurse who is a licensed, registered nurse with a master's degree in nursing with a major in psychiatric and mental health nursing from an accredited school of nursing
- Mid-level practitioners are not enrolled by the IHCP



Mental Health

Psychiatrist or HSPP responsibilities

- Must certify the diagnosis and supervise the plan of treatment as stated in *405 IAC 5-20-8 (3) (a)-(b)*
- Must see the patient or review information obtained by a mid-level practitioner within seven days of intake
- Must see the patient or review documentation to certify treatment plan and specific modalities at intervals not to exceed 90 days
- Must document and personally sign all reviews
 - No cosignatures on documentation
- Must be available for emergencies
 - An emergency is a sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in (1) danger to the individual, (2) danger to others, or (3) death of the individual



Mental Health

PA requirements

- Prior authorization (PA) is required for units in excess of 20 per member, per rendering provider, per rolling 12-month period:
 - Codes below in combination are subject to 20 units per member, per provider, per rolling 12-month period:
 - 90804 through 90815
 - 90845 through 90857
 - 96151 through 96153
- Requests for PA should include a current plan of treatment and progress notes to support the effectiveness of therapy
- Reference the *IHCP Provider Manual Chapter 6* for prior authorization guidelines and instructions
 - Managed care entities (MCEs) may have different PA requirements; providers are encouraged to contact each MCE for PA processes



Mental Health

What is a rolling 12-month period?

- A rolling 12-month period is:
 - Based on the first date that services are rendered by a particular provider
 - Renewable one unit at a time beginning 365 days after the date that services are rendered by a particular provider
- It is not:
 - Based on a 12-month calendar year
 - Based on a fiscal year
 - Renewable on January 1 of each year



Mental Health

Psychiatric diagnostic interview (90801)

- One unit of psychiatric diagnostic interview (90801) is allowed per member, per provider, per rolling 12-month period per *IAC 405 IAC 5-20-8 (14)*
- Additional units require PA
- Exception: Two units are allowed without PA if separate evaluations are performed by a psychiatrist or HSPP and a mid-level practitioner



Mental Health Prior Authorization

– Mail or Fax PA requests to:

ADVANTAGE Health Solutions-FFS

P.O. Box 40789

Indianapolis, IN 46240

Fax number: 1-800-689-2759

– For questions or inquiries, call 1-800-269-5720

– For Rick based managed care (RBMC) members, contact the appropriate Managed Care Entity (MCE)



Care Select Organizations – Prior Authorization

– ADVANTAGE Health Solutions

- advantageplan.com

P.O. Box 80068

Indianapolis, IN 46280

Phone: 1-800-784-3981

Fax request: 1-800-689-2759

– MDwise

- mdwise.org

P.O. Box 44214

Indianapolis, IN 46244-0214

Phone: 1-866-440-2449

Fax request: 1-877-822-7186



Physician, HSPP Covered Services

– Medical services provided by mid-level practitioners, such as clinical social workers, clinical psychologists, or any mid-level practitioners (excluding nurse practitioners and clinical nurse specialists) are not reimbursable for the following codes:

- 90805
- 90807
- 90809
- 90811
- 90813
- 90815
- 90862



Physician, HSPP Covered Services

- PA is always required for neuropsychological and psychological testing
 - 96101 – Psychological Testing
 - 96110 – Developmental Testing
 - 96111 – Developmental Testing Extended
 - 96118 – Neuropsychological Testing Battery
 - According to *405 IAC 5-2-8(7)*, a physician or HSPP must provide these services

Mental Health

Noncovered services

- Biofeedback
- Broken or missed appointments
- Day care
- Hypnosis



Mental Health

Billing overview

- Services are billed on the 837P or the CMS-1500 paper claim form
- Services are billed using the National Provider Identifier (NPI) of the facility or clinic, and the rendering NPI of the supervising psychiatrist or HSPP
- Medical records must document the services and the length of time of each therapy session
- Psychiatrists and HSPPs are reimbursed at 100 percent of the allowed amount
- Mid-level practitioners are reimbursed at 75 percent of the allowed amount
 - Services rendered by mid-level practitioners are billed using the rendering NPI of the overseeing provider



Mental Health

Billing overview

- Appropriate modifiers must be used for mid-level practitioners
 - AH – Clinical psychologist
 - AJ – Clinical social worker
 - HE and SA – Nurse practitioner or nurse specialist
 - HE – Any other mid-level practitioner as addressed in the *405 IAC 5-20-8*
 - HO – Master's degree level
 - SA – Nurse practitioner or clinical nursing specialist (CNS) in a nonmental health arena



Mental Health

Billing overview

- Mental health providers that submit claims with procedure codes and append modifier HE or HO when the member is dually eligible for Medicare and Medicaid may now utilize claim notes for billing to indicate that the provider has performed a service that is not approved to bill to Medicare
 - Claims submitted using claim notes must indicate in the claim notes on the 837P the following text: “Provider not approved to bill services to Medicare”
 - The use of claim notes allows the claim to suspend for review of the claim note and be adjudicated appropriately



Learn

MRO Services

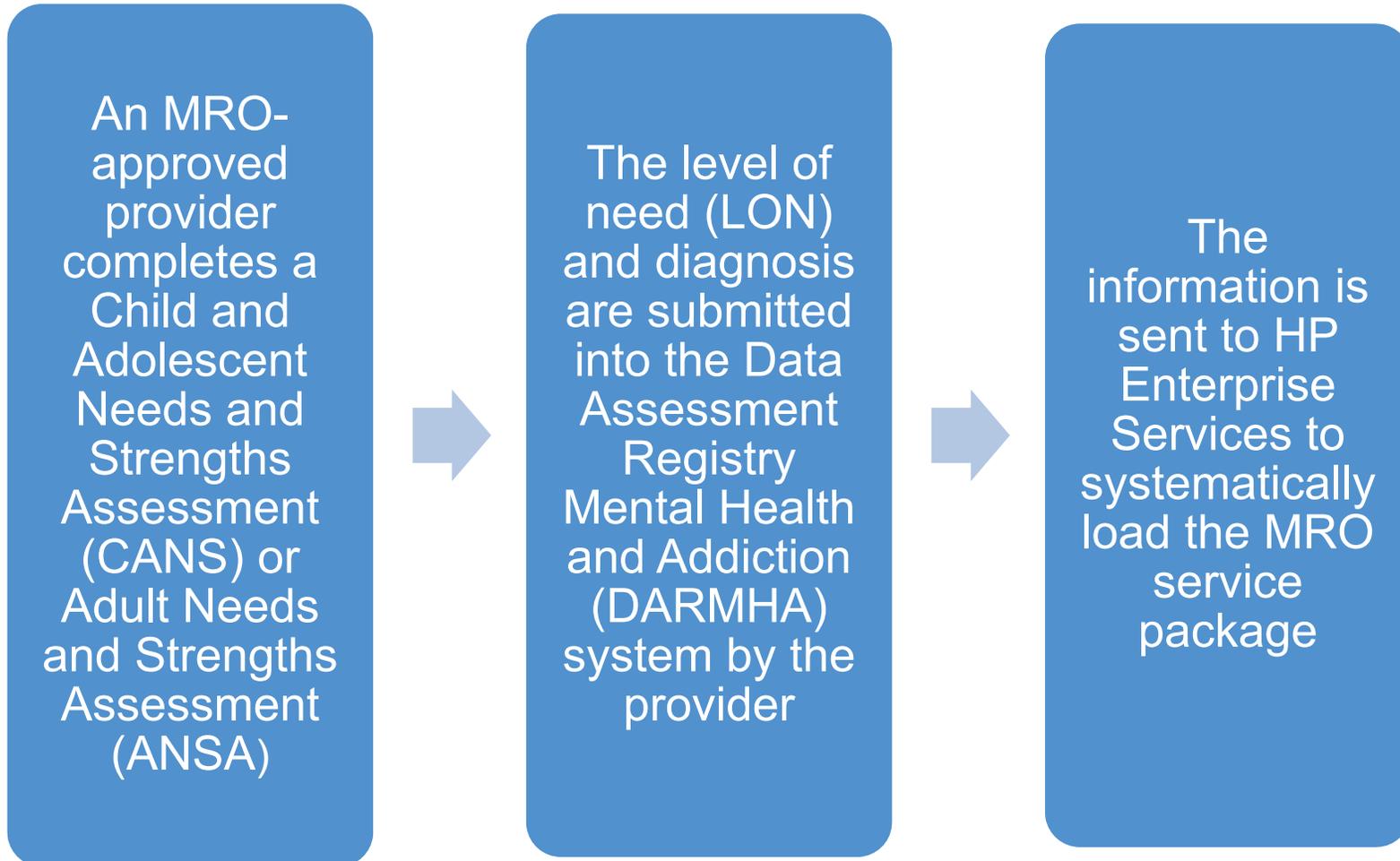
MRO (Medicaid Rehabilitation Option)

- The Office of Medicaid Policy and Planning (OMPP), in conjunction with the Division of Mental Health and Addiction (DMHA), developed a benefit plan structure for Medicaid members receiving MRO services
- While members can continue to access MRO providers based on a self-referral, members who have a qualifying MRO diagnosis will be assigned a service package based on their individual level of need (LON)

Importance of Verifying Eligibility

- It is important that providers verify member eligibility on the date of service
- Viewing a Hoosier Health card alone does not ensure member eligibility
- If a provider fails to verify eligibility on the date of service, the provider risks claim denial
- Claim denial could result if the member was not eligible on the date of service
- If the member is not eligible for Medicaid on the date of service, the member can be billed
 - If retroactive eligibility is later established, the provider must bill the IHCP and refund any payment made to the provider by the member

Service Package Process



When to Submit a Prior Authorization

- If a member requires additional medically necessary services, a PA request is required
- Please note that submitting a PA request for a full service package is not permitted
- Under the following four scenarios, an MRO service provider is required to submit a PA request to the PA vendor:
 - Scenario 1: A member depletes units within his or her MRO service package and requires additional units of a medically necessary MRO service.
 - Scenario 2: A member requires a medically necessary MRO service not authorized in his or her MRO service package.
 - Scenario 3: A member does not have one or more qualifying MRO diagnoses and/or LON for the assignment of an MRO service package, and has a significant behavioral health need that requires a medically necessary MRO service.
 - Scenario 4: A member is newly eligible to the Medicaid program or had a lapse in his or her Medicaid eligibility, and was determined Medicaid eligible for a retroactive period. In this case, a retroactive PA request is appropriate for MRO services provided during the retroactive period.



Prior Authorization

Prior authorization by telephone, fax, or mail

- **ADVANTAGE Health Solutions**
Prior Authorization Department
P.O. Box 40789
Indianapolis, IN 46240
- Phone: 1-800-269-5720
Fax: 1-800-689-2759



Medicaid Rehabilitation Option

- Medicaid Rehabilitation Option (MRO) services remain carved out of the risk-based managed care (RBMC) delivery system
- MRO services remain reimbursable only to providers enrolled as type 11 (mental health) with a specialty of 111 (community mental health center)
- Clinical mental health services are provided for individuals, families, or groups living in the community who need aid intermittently for emotional disturbances or mental illness
- Services must be reported with an HW modifier



MRO Covered Services

- The following services are covered:
 - Behavioral Health Counseling and Therapy (Individual and Group setting)
 - Behavioral Health Level of Need Redetermination
 - Case Management
 - Psychiatric Assessment and Intervention
 - Adult Intensive Rehabilitative Services (AIRS)
 - Child and Adolescent Intensive Resiliency Service (CAIRS)
 - Intensive Outpatient Treatment (IOT)
 - Addiction Counseling (Individual and Group setting)
 - Peer Recovery Services
 - Skills Training and Development (Individual and Group setting)
 - Medication Training and Support (Individual and Group setting)
 - Crisis Intervention
- **Reminder: Do not use mid-level modifiers when billing for MRO services**



MRO Provider Qualifications

- Three categories of provider types can render MRO services:
 - Licensed Professional
 - Qualified Behavioral Health Professional (QBHP)
 - Other Behavioral Health Professional (OBHP)
- For a detailed list of qualified providers, please see the following resources:
 - *MRO Provider Manual* located on the indianamedicaid.com Web site under Manuals
 - The Family Social Services Administration (FSSA) public Web site at <https://myshare.in.gov/FSSA/ompp/MRO/default.aspx>

Define

Risk-Based Managed Care (RBMC)

Risk-Based Managed Care

- Services that are the responsibility of the MCEs:
 - Office visits with a mental health diagnosis
 - Services ordered by a provider enrolled in a mental health specialty, but provided by a nonmental health specialty, such as a laboratory and radiology
 - Mental health services provided in an acute care hospital
 - Inpatient stays in an acute care hospital or freestanding psychiatric facility for treatment of substance abuse or chemical dependency



Risk-Based Managed Care

- Services provided to RBMC members by the following specialty types are the responsibility of the MCEs:
 - Freestanding Psychiatric Hospital (011)
 - Outpatient Mental Health Clinic (110)
 - Community Mental Health Center (111)
 - Psychologist (112)
 - Certified Psychologist (113)
 - HSPP (114)
 - Certified Clinical Social Worker (115)
 - Certified Social Worker (116)
 - Psychiatric Nurse (117)
 - Psychiatrist (339)



Risk-Based Managed Care

– MCEs

- Anthem anthem.com
- Managed Health Services (MHS) managedhealthservices.com
- MDwise mdwise.org

– Behavioral Health Organizations (BHO)

- Anthem anthem.com
- Cenpatico (MHS) cenpatico.com
- MDwise mdwise.org

Understand

Eligibility Verification System

Importance of Verifying Eligibility

- It is important that providers verify member eligibility on the date of service
- Viewing a Hoosier Health card alone does not ensure member eligibility
- If a provider fails to verify eligibility on the date of service, the provider risks claim denial
- Claim denial could result if the member was not eligible on the date of service
- If the member is not eligible on the date of service, the member can be billed for services
 - However, it is important to remember that if retroactive eligibility is later established, the provider must bill the IHCP and refund any payment made to the provider by the member

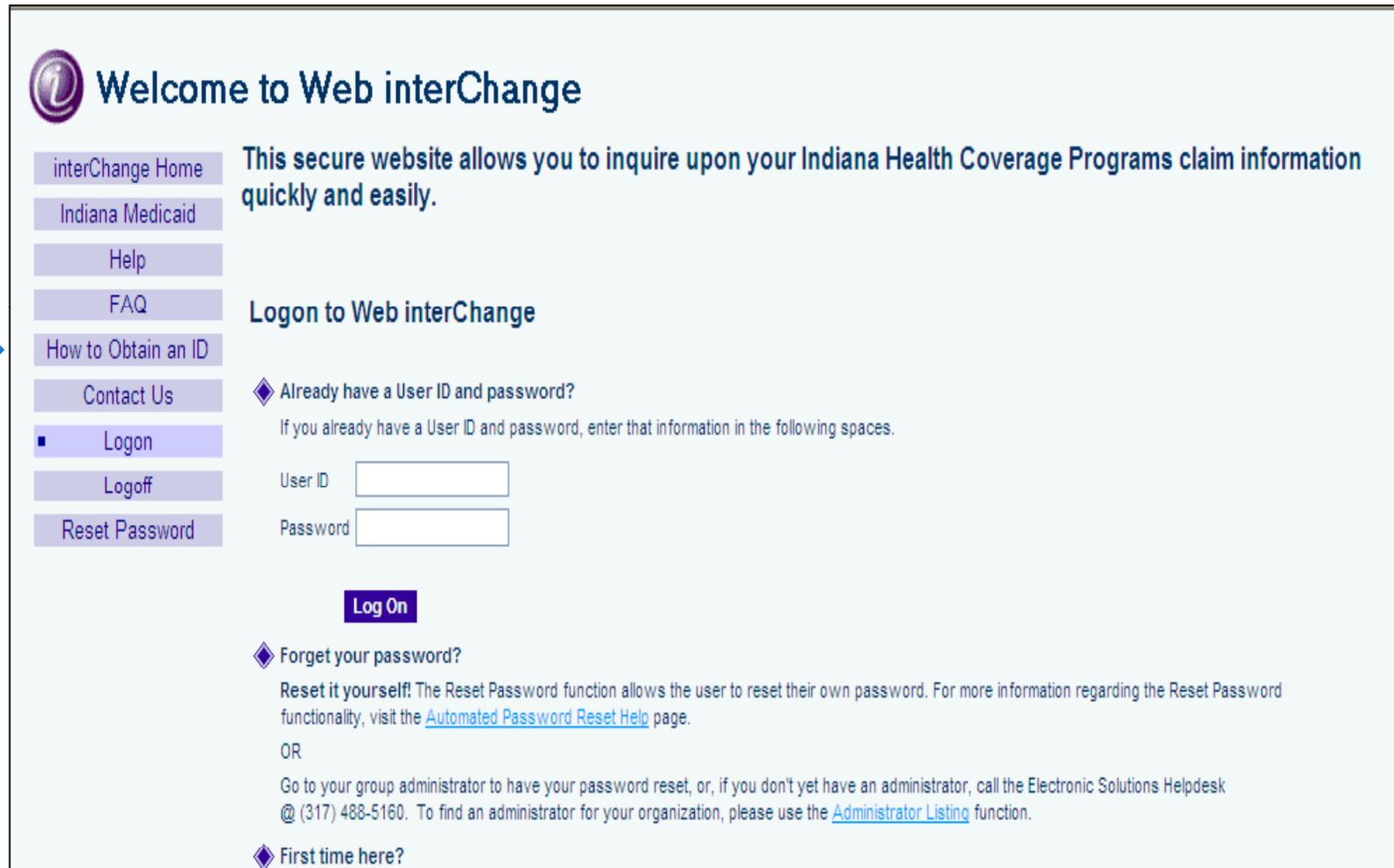
Methods to Verify Eligibility

- Providers can verify eligibility by using one of the following eligibility verification methods:
 - Web interChange
 - <https://interchange.indianamedicaid.com>
 - Omni swipe card device
 - Requires upgrade for benefit limit information (refer to IHCP Provider Bulletin *BT200711*)
 - Omni instructions are in Chapter 3 of the *IHCP Provider Manual*
 - Automated Voice Response (AVR)
 - Contact AVR at (317) 692-0819 in the Indianapolis local area or 1-800-738-6770
 - AVR instructions are in Chapter 3 of the *IHCP Provider Manual*

Providers using any of these systems may verify member eligibility seven days a week, 24 hours a day

Web interChange Access

<https://interchange.indianamedicaid.com>



Welcome to Web interChange

interChange Home This secure website allows you to inquire upon your Indiana Health Coverage Programs claim information quickly and easily.

Indiana Medicaid

Help

FAQ

How to Obtain an ID

Contact Us

Logon

Logoff

Reset Password

Logon to Web interChange

◆ Already have a User ID and password?
If you already have a User ID and password, enter that information in the following spaces.

User ID

Password

Log On

◆ Forget your password?
Reset it yourself! The Reset Password function allows the user to reset their own password. For more information regarding the Reset Password functionality, visit the [Automated Password Reset Help](#) page.
OR
Go to your group administrator to have your password reset, or, if you don't yet have an administrator, call the Electronic Solutions Helpdesk @ (317) 488-5160. To find an administrator for your organization, please use the [Administrator Listing](#) function.

◆ First time here?

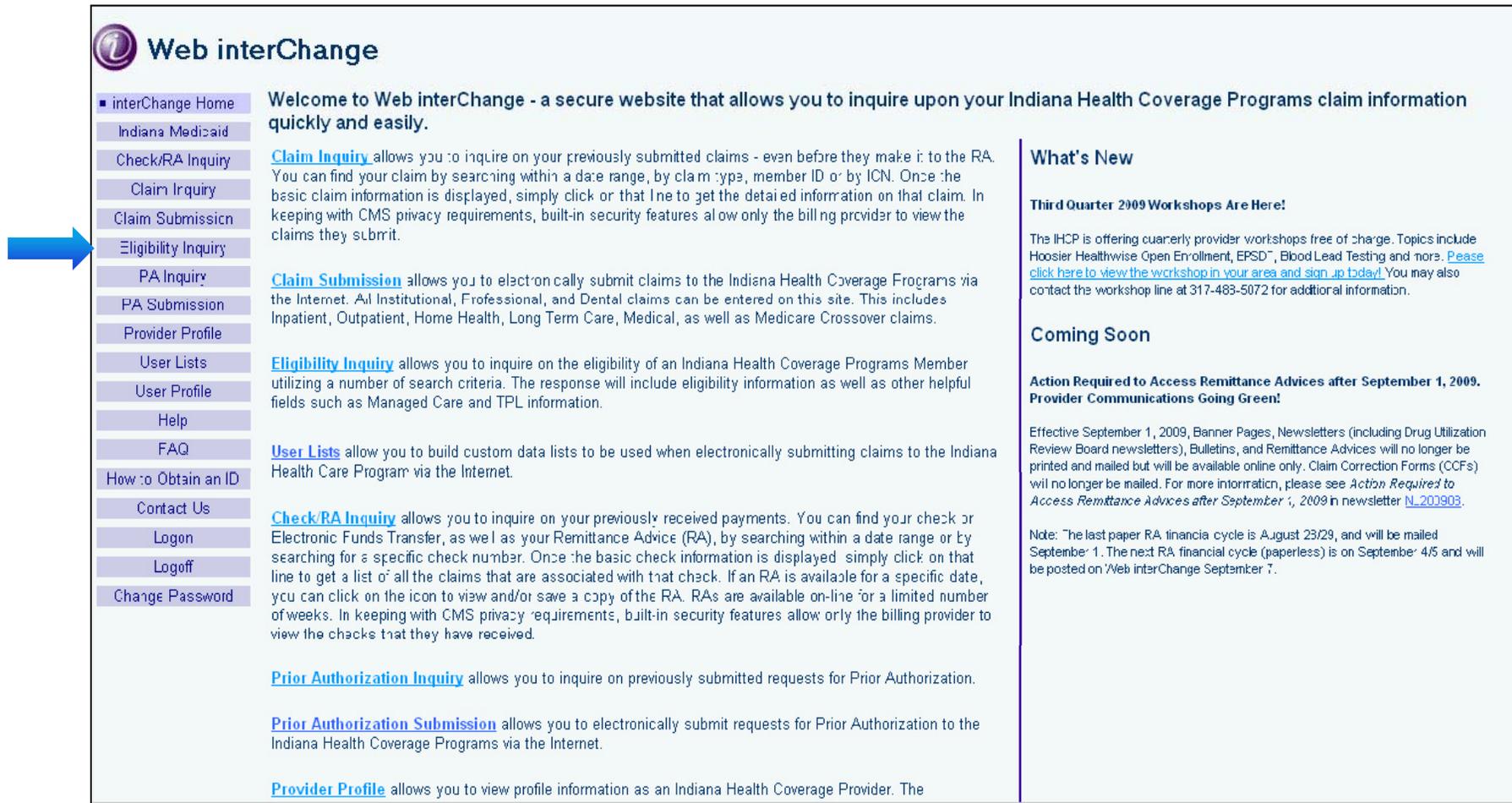
Administrator Request Form

- Complete and mail the Administrator Request Form and owner letter to:
 - Electronic Solutions Help Desk
950 N. Meridian Street
Suite 1150
Indianapolis, IN 46204-4288
- Request form and owner letter may be faxed to (317) 488-5185
- The owner letter indicates you are approved as a Web interChange administrator for your organization
- Each provider should assign a Web interChange administrator to oversee the daily functions of the individual practice or group



Web interChange Menu

Web interChange home page



Web interChange

- interChange Home
- Indiana Medicaid
- Check/RA Inquiry
- Claim Inquiry
- Claim Submission
- Eligibility Inquiry
- PA Inquiry
- PA Submission
- Provider Profile
- User Lists
- User Profile
- Help
- FAQ
- How to Obtain an ID
- Contact Us
- Logon
- Logout
- Change Password

Welcome to Web interChange - a secure website that allows you to inquire upon your Indiana Health Coverage Programs claim information quickly and easily.

Claim Inquiry allows you to inquire on your previously submitted claims - even before they make it to the RA. You can find your claim by searching within a date range, by claim type, member ID or by ICN. Once the basic claim information is displayed, simply click on that line to get the detailed information on that claim. In keeping with CMS privacy requirements, built-in security features allow only the billing provider to view the claims they submit.

Claim Submission allows you to electronically submit claims to the Indiana Health Coverage Programs via the Internet. All Institutional, Professional, and Dental claims can be entered on this site. This includes Inpatient, Outpatient, Home Health, Long Term Care, Medical, as well as Medicare Crossover claims.

Eligibility Inquiry allows you to inquire on the eligibility of an Indiana Health Coverage Programs Member utilizing a number of search criteria. The response will include eligibility information as well as other helpful fields such as Managed Care and TPL information.

User Lists allow you to build custom data lists to be used when electronically submitting claims to the Indiana Health Care Program via the Internet.

Check/RA Inquiry allows you to inquire on your previously received payments. You can find your check or Electronic Funds Transfer, as well as your Remittance Advice (RA), by searching within a date range or by searching for a specific check number. Once the basic check information is displayed simply click on that line to get a list of all the claims that are associated with that check. If an RA is available for a specific date, you can click on the icon to view and/or save a copy of the RA. RAs are available on-line for a limited number of weeks. In keeping with CMS privacy requirements, built-in security features allow only the billing provider to view the checks that they have received.

Prior Authorization Inquiry allows you to inquire on previously submitted requests for Prior Authorization.

Prior Authorization Submission allows you to electronically submit requests for Prior Authorization to the Indiana Health Coverage Programs via the Internet.

Provider Profile allows you to view profile information as an Indiana Health Coverage Provider. The

What's New

Third Quarter 2009 Workshops Are Here!

The IHCP is offering quarterly provider workshops free of charge. Topics include Hoosier Healthwise Open Enrollment, EPSDT, Blood Lead Testing and more. [Please click here to view the workshop in your area and sign up today!](#) You may also contact the workshop line at 317-483-5072 for additional information.

Coming Soon

Action Required to Access Remittance Advices after September 1, 2009. Provider Communications Going Green!

Effective September 1, 2009, Banner Pages, Newsletters (including Drug Utilization Review Board newsletters), Bulletins, and Remittance Advices will no longer be printed and mailed but will be available online only. Claim Correction Forms (CCFs) will no longer be mailed. For more information, please see *Action Required to Access Remittance Advices after September 1, 2009* in newsletter [N_200903](#).

Note: The last paper RA financial cycle is August 23/29, and will be mailed September 1. The next RA financial cycle (paperless) is on September 4/5 and will be posted on Web interChange September 7.



Verifying Member Eligibility

Eligibility Inquiry window

Eligibility Inquiry

interChange Home
Indiana Medicaid
Birth Expenditures
Check/RA Inquiry
Claim Inquiry
Claim Submission
CS Notif Inquiry
Eligibility Inquiry
HH Open Enrollment
MRO Inquiry
NOP Inquiry
PA Inquiry
PA Submission
PE Assignment
Pharm Member Profile
Provider Profile
User Lists
User Profile
Help
FAQ

Query Information

Search For: NPI Legacy Provider ID

NPI Taxonomy Code Postal Code -

Search Criteria: By Member ID

Member ID

From Date: 05/06/2010 To Date: 05/06/2010

Search **Reset**

Eligibility Information: None

Spend-Down: None

Managed Care Information: None

Third Party Carrier Information: None [TPL Update Request](#)

County Information: None

Benefit Limits Reached For Inquiring Provider Type: None

Eligibility Inquiry Window



Eligibility Inquiry

- interChange Home
- Indiana Medicaid
- Administration Menu
- Birth Expenditures
- Check/RA Inquiry
- Claim Inquiry
- Claim Submission
- CS Notif Inquiry
- Eligibility Inquiry
- File Exchange
- HH Open Enrollment
- NOP Inquiry
- PA Inquiry
- PA Submission
- PE Assignment
- Provider Profile
- User Lists
- User Profile
- Help
- FAQ
- How to Obtain an ID
- Contact Us
- Login
- Logout
- Change Password

Query Information

Search For: NPI Legacy Provider ID

NPI Taxonomy Code Postal Code -

Search Criteria:

Member ID

From Date: To Date:

Eligibility Information

Member is Eligible from 08/03/2009 to 08/03/2009 for PACKAGE A STANDARD PLAN

Inquiry completed at 10:15:00 AM on 8/3/2009

Member Name	Member ID
Address	
Date of Birth	12/01/1942
Spend Down	No
Medicare	No
Nursing Home Resident	No
Restricted	No
QMB	No
Other Private Insurance	No
Medicare Number	
Patient Liability	\$0.00

Managed Care Information

Managed Care: Care Select from 08/03/2009 to 08/03/2009

Primary Provider	Phone
Managed Care Entity Name	ADVANTAGE HEALTH SOLUTIONS INC
Phone	

Member is restricted to

39 Mental Health Guidelines and Billing Practices

July 2011

Learn

Web interChange and CMS-1500 Billing Guidelines

Claims Processing Menu

The screenshot shows a web interface for the Claims Processing Menu. On the left is a vertical navigation menu with buttons for: interChange Home, Indiana Medicaid, Birth Expenditures, Check Inquiry, Claim Inquiry, Claim Submission (highlighted with a square bullet), Eligibility Inquiry, NOP Inquiry, PA Inquiry, Provider Profile, User Lists, User Profile, Help, FAQ, How to Obtain an ID, Contact Us, Logon, Logoff, and Change Password. The main content area is titled "Claims Processing Menu" and contains three sections: "Institutional Claims" with links for Inpatient, Outpatient, Home Health, Long Term Care, Institutional Crossover, and Outpatient Crossover; "Professional Claims" with links for Medical (includes HCBS Waiver) and Medical Crossover; and "Dental Claims" with a link for Dental. The "Medical (includes HCBS Waiver)" link is circled in black. At the bottom, a "Helpful Hints" box contains four diamond-shaped icons and text: "Use the [NPI Reporting Tool](#) to report your National Provider Identifier (NPI) to IHCP.", "Click on any field label to get more information about the field.", "Review the [Help Page](#) to find more information about how to use this site.", and "Please direct comments, problems or suggestions concerning using this site to [Indiana Medicaid](#)."

Professional Claim



Professional Claim

* denotes a required field.

Billing Information

* NPI <input type="text"/>	Postal Code <input type="text"/> - <input type="text"/>	Taxonomy <input type="text"/>
* Legacy Provider Id <input type="text"/>		
* Member ID <input type="text"/>		
* Last Name <input type="text"/>	* First Name <input type="text"/>	* Patient Account # <input type="text"/>
Rendering Provider <input type="text"/>	Rendering NPI <input type="text"/>	Rendering Taxonomy <input type="text"/>
Referring Provider <input type="text"/>	Referring NPI <input type="text"/>	Referring Taxonomy <input type="text"/>
Certification Code <input type="text"/>	* Signature Indicator <input checked="" type="radio"/> Yes <input type="radio"/> No	Medical Record # <input type="text"/>

Notes...
Attachments...

Service Information

Claim Type Medical Crossover	* Place of Service <input type="text"/>
Hospital From Date <input type="text"/>	Hospital To Date <input type="text"/>
Pregnancy? <input type="radio"/> Yes <input checked="" type="radio"/> No	Last Menstrual Period <input type="text"/>
Accident: Related to <input type="checkbox"/> Auto <input type="checkbox"/> Employment <input type="checkbox"/> Other Accident <input type="checkbox"/> Special Program <input type="checkbox"/>	

Coordination of Benefits

Total TPL	<input type="text"/>
Total Medicare Paid	<input type="text"/>

Benefit Information

Billing Codes

Diagnosis Code

Primary <input type="text"/>	Diag 2 <input type="text"/>	Diag 3 <input type="text"/>	Diag 4 <input type="text"/>
------------------------------	-----------------------------	-----------------------------	-----------------------------

Charges

Total Charges	<input type="text"/>
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Web interChange Claim Submission

- Under the Professional heading, click the Medical link
- Your Billing National Provider Identifier (NPI) will automatically populate in the NPI field
- Complete the fields:
 - Member's ID
 - Last Name, First Name
 - Patient Acct #, Rendering NPI
 - Place of Service
 - Diagnosis Code(s)



Professional Claim

Detail #	1	* From DOS	<input type="text"/>	* To DOS	<input type="text"/>
Place of Service	<input type="text"/>	* Procedure Code	<input type="text"/>	Modifiers	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Related Diagnosis	<input type="text"/>	* Units	<input type="text"/>	* Charges	<input type="text"/>
* Emergency?	<input type="radio"/> Yes <input checked="" type="radio"/> No	Line Item Control #	<input type="text"/>	* EPSDT Referral	<input type="radio"/> Yes <input checked="" type="radio"/> No
Rendering Provider	<input type="text"/>	Rendering NPI	<input type="text"/>	Rendering Taxonomy	<input type="text"/>
NDC	<input type="text"/>	Quantity	<input type="text"/>	Unit of Measure	<input type="text"/>

Detail #	From DOS	To DOS	Procedure	Modifiers	Units	Charges

Helpful Hints

- ◆ Use the [NPI Reporting Tool](#) to report your National Provider Identifier (NPI) to HCP.
- ◆ Click on any field label to get more information about the field.
- ◆ Review the [Help Page](#) to find more information about how to use this site.
- ◆ Please direct comments, problems or suggestions concerning using this site to [Indiana Medicaid](#).



Web interChange Claim Submission

Detail Information

- From DOS, To DOS
- Procedure Code, Modifiers
- Related Diagnosis (if needed)
- Units
- Charges
- Click **Save Detail** and a summary of the detail information displays in the box at the bottom of the screen to confirm that the information saved
- Click **Submit Claim** on the bottom of the screen
- When the confirmation pop-up window appears with the claim's internal control number (ICN), confirm the information, and click **OK** to complete the process and send the claim to HP

Note: Users who are running pop-up blockers will not see the confirmation window. Please disable all pop-up blockers when using Web interChange.



CMS-1500 Claim Form

<div style="border: 1px solid black; padding: 2px; display: inline-block;">1500</div> HEALTH INSURANCE CLAIM FORM <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</small>										<small>PICA</small> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> SEL LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN)</small>				1a. INSURED'S I.D. NUMBER (For Program in Item 1)							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE <small>MM DD YY</small>		SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER					
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH <small>MM DD YY</small> M <input type="checkbox"/> F <input type="checkbox"/>					
b. OTHER INSURED'S DATE OF BIRTH <small>MM DD YY</small> M <input type="checkbox"/> F <input type="checkbox"/>				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME					
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete Item 9 a-d.</i>					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.						
SIGNED _____ DATE _____					SIGNED _____						
14. DATE OF CURRENT: <small>MM DD YY</small>				ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE <small>MM DD YY</small>		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM <small>MM DD YY</small> TO <small>MM DD YY</small>			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. _____		17b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM <small>MM DD YY</small> TO <small>MM DD YY</small>			
19. RESERVED FOR LOCAL USE				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____		22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)				23. PRIOR AUTHORIZATION NUMBER							
1. _____				3. _____							
2. _____				4. _____							
24. A. DATE(S) OF SERVICE From <small>MM DD YY</small> To <small>MM DD YY</small>		B. PLACE OF SERVICE EMG	C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. ERSBT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN			26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$	30. BALANCE DUE \$
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)			32. SERVICE FACILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO & PH # ()					
SIGNED _____ DATE _____			a. _____ b. _____			a. _____ b. _____					

NUCC Instruction Manual available at: www.nucc.org APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)



CMS-1500 Billing Guidelines

- 1a INSURED'S I.D. NUMBER
- 2 PATIENT'S NAME
- 21.1 to 21.4. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
- 23 PRIOR AUTHORIZATION NUMBER – The prior authorization (PA) number is not required, but entry is recommended to assist in tracking services that require PA
- 24A DATE OF SERVICE
- 24B PLACE OF SERVICE – Use the POS code for the facility where services were rendered
- 24D HCPCS and MODIFIER – Use the appropriate procedure code for the service rendered
- 24E DIAGNOSIS POINTER
- 24F CHARGES
- 24G DAYS OR UNITS



CMS-1500 Billing Guidelines

- 24 J Bottom Half RENDERING PROVIDER ID# NPI – Enter the NPI of the rendering provider.
- 28 TOTAL CHARGE
- 30 BALANCE DUE
- 31 SIGNATURE OF PHYSICIAN – An authorized person, someone designated by the agency or organization, must sign and date the claim. A signature stamp is acceptable; however, a typed name is not. Providers who have signed the *Signature on File* certification form will have their claims processed when a signature is omitted from this field. The form is available on the *Provider Services* page on indianamedicaid.com
- 32 SERVICE FACILITY LOCATION INFORMATION – Enter the provider's name and address where the services were rendered, if other than home or office. This field is optional, but it helps HP contact the provider, if necessary.
- 33 BILLING PROVIDER INFO – Enter the billing provider service location name, address, and the expanded ZIP Code + 4 format. Required.



Additional Billing Resources

- Paper billing resources
 - *IHCP Provider Manual* on the indianamedicaid.com *Manuals* Page – Chapter 8, Section 4
- Web interChange resources
 - Quick Reference for billing medical claims

Claim Inquiry

To view claim status on submitted claims

The screenshot displays the 'Claim Inquiry' web application. On the left is a vertical navigation menu with items such as 'interChange Home', 'Indiana Medicaid', 'Birth Expenditures', 'Check/RA Inquiry', 'Claim Inquiry' (highlighted with a blue arrow), 'Claim Submission', 'CS Notif Inquiry', 'Eligibility Inquiry', 'HH Open Enrollment', 'MRO Inquiry', 'NOP Inquiry', 'PA Inquiry', 'PA Submission', 'PE Assignment', 'Pharm Member Profile', 'Provider Profile', 'User Lists', 'User Profile', 'Help', and 'FAQ'. The main content area is titled 'Claim Inquiry' and contains two search panels. The 'Provider/Member ID/ICN' panel includes search options for NPI (selected) and Legacy Provider ID, with input fields for NPI, Taxonomy Code, Postal Code, Member ID, and ICN. The 'Claim Information' panel includes dropdowns for Claim Status (Any Status) and Claim Type (Any Claim), date pickers for From Date (4/29/2010) and To Date (5/6/2010), and a Date Type dropdown (RA Date). Below these panels are 'Search' and 'Reset' buttons. At the bottom, a table header is visible with columns: ICN, Member ID, First Date, Last Date, Billed Amount, Paid Amount, RA Date, Type, and Status.

Find Help

Resources Available

Helpful Tools

- IHCP Web site at indianamedicaid.com
- IHCP Provider Manual
- MRO Provider Manual
 - 405 IAC 5-20 (Mental Health Services)
 - 405 IAC 5-21 (Community Mental Health Rehabilitation Services)
 - 405 IAC 5-21.5 (Medicaid Rehabilitation Option Services)
- Customer Assistance
 - 1-800-577-1278 toll-free
 - (317) 655-3240 in the Indianapolis local area
- HP Written Correspondence at the following address:
HP Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263
- Provider Relations field consultants



Q&A